

Fiscal Agent for Virginia's Medical Assistance Program - Provider Enrollment Unit

Date

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed agreement forms, processing the enrollment may take up to 15 business days. **First Health** is unable to accept altered agreements, agreements via fax, agreements with non-original signatures or agreements on thermal paper.

Enclosed are blank agreement forms. Please verify all required information is complete to expedite the enrollment process.

	Signature is in ink on agreement forms
$\boxtimes$	Agreement forms may not be altered.
	Agreements may not be faxed.

- 1. The beginning date of coverage is based upon the date authorized by the Department of Education.
- 2. Enclose a copy of your certification from the Department of Education.
- 3. EMC billing information.
  - Billing by tape, diskette, or dial-up, contact First Health-VMAP at (804) 273-6779 for accepted formats.
- 4. If you have questions, call 1-804-270-5105. Please complete and return to **First Health** at the following address:

First Health VMAP-PEU

PO Box 26803 Richmond, VA 23261-6803

# Commonwealth of Virginia Department of Medical Assistance Services Medical Assistance Program

## **School Division Participation Agreement**

If re-enrolling, enter Med	dicaid Provider Number here→	Check this	box if requesting new number→
This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS		AL ADDRESS ENT FROM PAYMENT ADDRESS)
PROVIDER NAME			
ATTENTION			
ADDR LINE 1			
ADDR LINE 2			
CITY, STATE, ZIP			
Program (VMAP), The provider agree providing the servi 1. Services will I individual sha discrimination 2. The provider regarding pay representative reasonable red 3. The provider at 4. Payment made submit addition consideration 5. The provider at 6. Payment by VI by authorized reimburse VM. 7. The provider at time to time at 8. This agreement eligible to part administrative such administrative such administrative aprovider or off The provider agreefunds for all Medic Fiscal Director and	grees to care for patients at the current rate established be by VMAP constitutes full payment except for patient parall charges to the recipient for services covered under V from or on behalf of a medical assistance recipient for any grees to pursue all other available third party payment so MAP at its established rates for the services involved shall state or federal officials result in disallowance of amount and a management of the services involved shall state or federal officials result in disallowance of amount and a management and federal laws mended.  In the program, and the provider reimbursement and/or termination of the proceedings conducted at the office of VMAP in Richmon proceedings conducted at the office of VMAP in Richmon proceedings shall be pursuant to the Virginia Admin agrees, at all times, to retain full responsibility for any and the services and the contract to the provider. The services to submit, no later than the 15th calendar day from the said payments received during that quarter. The certifical signed by the Superintendent of the School Division or the MAP denial of Medicaid funding for provision of those	gally designated State Agency for by the Department of Education argion, national origin, or type of illim participation in, be denied the 94) VMAP.  Cessary. The provider will furniste Plan. Access to records and ed representatives, and federal personal	d assures that those individuals all assures condition. No handicapped benefits of, or be subjected to the VMAP on request information facilities by authorized VMAP arsonnel will be permitted upon and the provider agrees not to any money, gift, donation or other assistance is expressly prohibited. VMAP. The provider will and procedures of VMAP as from when the provider is no longer asson shall be resolved through proceedings and judicial review of ament, whether performed by the diffication of State/Local matching by VMAP, submitted to the DMAS this certification by the due date
contingent up	nt shall commence on Yon the timely renewal of your license. Failure to renew your Medicaid Participation Agreement.		
F= =: ::		For Provider of Services:	
For First Health's u	<u> </u>	ginal Signature	Dete
	Ong	giriai Sigilature	Date
	Title		
Director, Division of	Program Operations Date	City ORCounty of	
			(Area Code) Telephone Number
IRS Identification N	lame (Required)	Identification Number (Required)	
mail <u>one</u> complete original agreement	d First Health - VMAP-Provider Enrollment Unit PO Box 26803	,	
to:	Richmond, Virginia 23261-6803		

PCT 72 FH/REV 09/11/2000

## Commonwealth of Virginia Department of Medical Assistance Services Medical Assistance Program

### **School-Based Clinic Participation Agreement**

If re-enrolling, ent	er Medicaid Provider # here→		Enter school division	Medicaid Provider # here→	
his is to certify:	PAYMENT/CORRE	SPONDENCE ADDRESS		PHYSICAL ADDRES	-
AME					
TENTION					
DDR LINE 1					
DDR LINE 2					
TY, STATE, ZIP					
The applicant hais not as a matter The applicant slassociation of hillness or conditional benefits of, or be Services rendered The applicant aregarding paymere reasonable requested The applicant and agrees that all repayment made submit additional consideration for prohibited. The applicant agreement by VMA by authorized serimburse VMAF The applicant agreement to time to	grees that charges submitted the submitted the submitted that the subm	an authorized to practic qualified from participat use a recipient in accores will be provided with vidual shall, solely by ren in (Section 504 of the Payment is to be made is as VMAP determines g services under the of Virginia or his authorized authorized as services rendered and the services covered under the authorized assistance recipients and the services involved sult in disallowance of plicable state and feder in thirty days' written not ment and/or termination in eoffice of VMAP in Rice pursuant to the Virginian I cense. Failure to reservices.	the under the laws of the string in the Program.  dance with the principles hout regard to age, sex, eason of his handicap, be Rehabilitation Act of 1973 only to those providers were recessary. The application of the program of the	state in which he is license state in which he excluded from participal 29 USC.794) VMAP. Who actually render the selant will furnish VMAP on a records and facilities land federal personnel will usual, customary, and rear the submission of claims and by VMAP, and the apor receipt of any money, cycled under medical assisting a claim to VMAP. The ent for the services rended to the provider by VMAP when the provider is MAP when the provider is MAP for any reason shall administrative proceeding Act.	ed and practicing and as of the professional origin, or type of the professional origin, or type of the profession in, be denied the rvices.  Trequest information by authorized VMAP and the permitted upon sonable concept and plicant agrees not to gift, donation or other distance is expressly ared. Should an audit AP, the provider will be cedures of VMAP as an olonger eligible to be resolved through is and judicial review
For FIRST HEALTH's	use only		- FOI FIO	vider of Services.	
			Original Signature of Super	intendent	Date
			Signature of Supervising Pl	nysician	
Director, Division of Pr	ogram Operations	Date	City ORCounty	of	
			IRS Identification Number	(Area Code	e) Telephone Number
IRS Name (required) mail one completed original agreement	FIRST HEALTH - VMAP-Provide PO Box 26803	er Enrollment Unit	Supervising Physician's Bo	ard of Medicine License Numb	er
to:	Richmond, VA 23261-6803		Name of Supervising Physic	cian CLIA Number	

PCT 72 FH/REV 09/11/2000



#### MAILING SUSPENSION REQUEST SERVICE CENTER AUTHORIZATION SIGNATURE WAIVER PHARMACY POINT-OF-SALE

Ple

			updates under the Medicaid pr	ovider number
I certify	R GENERATED CLA that I have authorized diskette or tape) to Virg	d the following service center	r to submit computer-generated	l invoices (by
		(Service Center Preparing In	nvoices)	_
Service o	center code:	Magnetic Tape R	A: YES NO (Circle One)	
Prior ser	vice center code:			
PHARMAC I wish to I understand that I a accurate, and comple	submit Point-of-Sale b am responsible for the te. I further understan- claims, statements, doc	AUTHORIZATION (in-state illings to Virginia Medicaid.  information presented on the d that payment and satisfaction	providers only):  ese invoices and that the inform of these claims will be from fererial facts may be prosecuted un	deral and state
		Leave		
SIGNAT	URE:			
D	ATE:			
TELEPHO	ONE #			
Please return complet	ted form to:	<b>First Health</b> VMAP-PEU PO Box 26803		

Signature waiver.doc FH Rev 07/13/2000 wm

Richmond, Virginia 23261-6803 1-804-270-5105

#### Commonwealth of Virginia **Department of Medical Assistance Services Medical Assistance Program**

### **School-Based Clinic Participation Agreement**

ATTENTION  ADDR LINE 1  ADDR LINE 2  CITY, STATE, ZIP  On this day of, agrees to participate in the Virginia Medical Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration 1. The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.  2. The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national originless or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.  3. Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.		r school division Medicaid Provider # ${\sf here}{ ightarrow}$	er Medicaid Provider # here→ Ente	If re-enrolling, en
<ol> <li>The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.</li> <li>Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.</li> </ol>	ENT ADDRESS)	PHYSICAL ADDRESS (REQUIRED IF DIFFERENT FROM PAYMENT AD	PAYMENT/CORRESPONDENCE ADDRESS	Γhis is to certify:
ADDR LINE 2  CITY, STATE, ZIP  on this day of, agrees to participate in the Virginia Medical Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration  1. The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.  2. The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.  3. Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.				NAME
ADDR LINE 2  CITY, STATE, ZIP  on this day of, agrees to participate in the Virginia Medical Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration  1. The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.  2. The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.  3. Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.				ATTENTION
on this day of, agrees to participate in the Virginia Medical Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration  1. The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.  2. The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.  3. Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.				ADDR LINE 1
on this day of, agrees to participate in the Virginia Medical Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration.  The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.  The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.  Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.				ADDR LINE 2
<ol> <li>The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.</li> <li>The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.</li> <li>Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.</li> </ol>				CITY, STATE, ZIP
<ol> <li>The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed a and is not as a matter of state or federal law disqualified from participating in the Program.</li> <li>The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origillness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.</li> <li>Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.</li> </ol>	Assistance of Medicaid.	agrees to participate in the Virginia Medical Assis lesignated State Agency for the administration of Me	ay of, , le Department of Medical Assistance Services, the legally	on this or Program (VMAP),
<ol> <li>The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on requer regarding payments claimed for providing services under the State Plan. Access to records and facilities by auth representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be preasonable request.</li> <li>The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.</li> <li>Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gif other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance prohibited.</li> <li>The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.</li> <li>Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendere audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the reimburse VMAP upon demand.</li> <li>The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedure from time to time amended.</li> <li>This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is not participate in the Program.</li> <li>All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be readministrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings shall be pursuant to the Virginia Admin</li></ol>	igin, or type of be denied the est information horized VMAP ermitted upon the concept and the agrees not to fit, donation or ce is expressly ed. Should an he provider will es of VMAP as longer eligible solved through judicial review id Program is	th the principles of the standards of ethics of the profed to age, sex, race, color, religion, national origin, or is handicap, be excluded from participation in, be deation Act of 1973 29 USC.794) VMAP.  Incompression of the services of the applicant will furnish VMAP on request inform. Access to records and facilities by authorized presentatives, and federal personnel will be permitted based on the usual, customary, and reasonable concises of VMAP for the submission of claims.  Incompression of the collection or receipt of any money, gift, done any service provided under medical assistance is expected by the provider by VMAP.  In the collection of the services rendered. Should be serviced by the provider by VMAP, the provider services and procedures of VMAP when the provider is no longer greement by VMAP for any reason shall be resolved iriginia. These administrative proceedings and judicial strative Process Act.	nall be free to accept or refuse a recipient in accordance will is area of practice. Services will be provided without regation. No handicapped individual shall, solely by reason of he subjected to discrimination in (Section 504 of the Rehabilited must be those provided. Payment is to be made only to taggrees to keep such records as VMAP determines necessatents claimed for providing services under the State Pland the Attorney General of Virginia or his authorized reset.  Grees that charges submitted for services rendered will be equests for payment will comply in all respects with the policy VMAP constitutes full payment except for patient pay and charges to the recipient for services covered under VM/zeron or on behalf of a medical assistance recipient for prees to pursue all other available third party payment source. AP at its established rates for the services involved shall be pursued to comply with all applicable state and federal laws, the amended.  The provider reimbursement and/or termination of this are recedings conducted at the office of VMAP in Richmond, trative proceedings shall be pursuant to the Virginia Adminishall commence on Your the timely renewal of your license. Failure to renew your the timely renewal of your license.	2. The applicant sassociation of illness or condidentities of, or services rended. The applicant regarding pay representatives reasonable requires that all agrees that all submit addition other consider prohibited. The applicant as audit by authore imburse VMA audit by authore imburse view of such administrative of such administrative of such agreement contingent upon the services in the sassociation of the services of such administrative of such agreement upon in the sassociation of the s
For Provider of Services:  For FIRST HEALTH's use only		For Provider of Services:	use only	For FIRST HEALTH
	Date	ignature of Superintendent Date	,	
Signature of Supervising Physician City ORCounty of		. 5 ,	Cit	
Director, Division of Program Operations  Date  IRS Identification Number (Area Code) Telepi	phone Number	fication Number (Area Code) Telephone N		Director, Division of F